Chapter DCF 37

APPENDIX B

INFORMATION FOR FOSTER PARENTS
CHECKLIST

		Yes	No	NK *	If "Yes", please comment
1.	Previous hospitalizations				
	a. Was anesthesia used? b. Problems with anesthesia?				
2.	Previous serious illnesses or injuries				
3.	Has child had any other medical tests (e.g., CAT Scan, EEG, MRI)?				
4.	Taking any medication including birth control pills or the use of birth control devices which require a prescription or other involvement of a physician? (If "Yes", name of medication, dosage, reason, prescription or over the counter, how given, by whom, who prescribed).				
5.	Immunizations (Indicate date(s))				**Date(s)**
	DPT (infants) (Diphtheria, Pertussis, Tetanus)				
	Polio (type: TOPV−Oral or IPV−Injectable)				
	MMR (Measles, Mumps, Rubella)				
	Flu				
	Pneumonia				
	Hepatitis B				
6.	Significant biological family medical history: (e.g., cancer, heart problems)				
7.	Medical needs				
	Apnea monitor				
	Gastrostomy				
	Tracheotomy				
	Ventilator				
	Heart monitor				
	Other (specify)				
8.	Degenerative disorder				
9.	Allergies, including animals, insect bites/stings, soap, wool, food, drugs, milk. (If "Yes", to what, symptoms, treatment)				
10.	Child has or ever had the following: (If yes, date child had it)				**Date(s)**
	7−day Measles				
	3−day German Measles				
	Chicken Pox				
	Rubella				
	Mumps				
	Whooping Cough				
	Scarlet Fever				

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		Yes	No	NK *	If "Yes", please comment
	Strep Throat				
	Impetigo				
	Lice				
	Worms				
	Sexually Transmitted Disease				
	Hepatitis B				
	Polio				
	Pneumonia				
	Mononucleosis				
	Scabies				
	Other				
11.	Current dental problems				
	Braces or retainers?				
	Bridges or dentures?				
	Last dental exam date? _____				
12.	Appetite above or below normal				
	Balanced diet				
	Unusual eating patterns/habits (e.g., large sugar intake, no vegetables)				
13.	Abdominal Concerns				
	Has had an ulcer or heartburn				
	Child regularly uses Tums or other antacid				
	Frequent nausea or vomiting				
	Child drinks caffeinated coffee or cola. How much per day?				
	Has had "yellow jaundice" or liver disease				
	Gets abdominal pain				
	Child uses laxatives. How often?				
	Becomes constipated or gets diarrhea				
	Has had blood in stool recently				
	Special diet needs (religious, medical, philosophical, vitamin/mineral supplements, etc.)				
14.	Anorexia/bulimia/other eating disorders. Ever had treatment?				
15.	Headaches				
	Migraine				
16.	Coordination or balance problems/dizziness				
	Has had serious head injury or loss of consciousness				

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		Yes	No	NK *	If "Yes", please comment
	Numbness or loss of strength in hand, arm or leg				
	Any trouble with swallowing or speaking				
17.	Has had a seizure				
	Has had epilepsy				
	Type and frequency of seizures				
	How to respond				
	Controlled or uncontrolled				
	Ever hospitalized for seizures				
	Ongoing medicines for seizures				
18.	Does child wear glasses? If yes, for how long?				
	Last eye exam (date, Dr.'s name)				
	Blurred or double vision				
	Contact lenses				
19.	Has hearing problem				
	Ringing in ears				
	Discharge or infection in ears				
	Tube(s) in ears				
20.	Blocking of nose, discharge, post−nasal drip				
	Nose bleeds				
	Persistent hoarseness				
21.	Treatment for skin trouble, rashes, hives, acne, or breaking out				
22.	Has had bursitis, sprain or dislocation of bone or joint				
	Cramps or pain in legs				
	Backaches				
	Arthritis				
23.	Thyroid problems				
24.	Child has had test for AIDS/HIV (If yes, date: _____)				Results:
25.	Child has had test for Hepatitis (If yes, (date: _____)				Results:
26.	Chest pain or discomfort/heart concerns				
	Asthma or wheezing				
	Cough, phlegm, bronchitis				
	Has coughed up blood				
	Smoke? If yes, how long? How much?				
	TB skin test. If yes, when? Results?				
	Heart trouble				

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		Yes	No	NK *	If "Yes", please comment
	Rheumatic Fever				
	Has had electrocardiogram (EKG)				
	Has had chest X−ray. If yes, when was last one?				
	Heart murmur				
	High or low blood pressure. Last check up?				
	Irregular heart beat				
	Shortage of breath				
	Swollen ankles				
	How many pillows does child sleep on?				
27.	Urinary or prostate problems/Gall bladder				
	Incontinence, urine or fecal				
	Bleeding or burning when urinating				
	Abnormally frequent urination				
	Has had kidney or gall bladder stone				
28.	Anemia				
29.	Blood problems				
30.	Cancer, leukemia, or other malignancy				
31.	History of abusing or not taking prescribed medications				
32.	Alcohol use or abuse				
33.	Other drug use or abuse				
	AODA treatment				
34.	Is child menstruating?				
	Child understands menstruation				
	Child's periods are normal				
	Excessive cramping or pain				
	PMS symptoms				
	Medication for cramps. If yes, what medication?				
	Bleeding or discharge other than when menstruating				
	Has had a "yeast" infection				
	Has had a "Pap" test. If yes, when? Why? Abnormal results?				
35.	Child has physical or developmental disabilities				
	If yes, what type of disability?				
	Autism				
	Blindness				
	Cerebral Palsy				

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	Yes	No	NK *	If "Yes", please comment
Deafness				
Dyslexia				
Emotional Disturbance				
Epilepsy				
Fetal Alcohol Effect				
Fetal Alcohol Syndrome				
Mental Retardation				
Muscular Dystrophy				
Neurological Impairment				
Physical Impairment				
Other (specify):				
Restrictions on Activities (e.g., lifting, driving, riding bikes)				
Special equipment (e.g., cane, walker, wheelchair)				
36. Considering the age of the child, his/her abilities are are not appropriate for:				
Bathing				
Feeding				
Toileting				
Dressing				
Learning				
Receptive Language				
Mobility				
Danger Awareness				
Social/Emotional Functioning				
Capacity for Independent Living				
Other (specify):				
37. Limitations in verbal skills. (If yes, also check a or b below)				
a. Child is non−verbal				
b. Child has very limited verbal skills				
38. History of behavioral or emotional problems				
39. History of treatment for behavioral or emotional problems at a clinic or hospital				
40. Someone in child's immediate family has been treated or hospitalized for emotional or mental health problems. (If yes, also check below)				
Depression				
Anxiety				
Mood swings				

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		Yes	No	NK *	If "Yes", please comment
	Suicide attempts				
	AODA				
	Mental Health				
41.	Has the child ever:				
	Felt hopeless or depressed				
	Had unexplained crying spells				
	Planned or attempted suicide				
	Had peculiar or bizarre thoughts				
	Had trouble eating or sleeping (either too much or too little)				
	Had an excess of energy or activity				
	Felt like hurting him/her self				
	Displayed reckless or dangerous behavior				
	Heard things no one else around him/her heard				
	Shown inappropriate emotions (reactions that didn't make sense in the situation).				
	Assaulted anyone physically (if yes, who, how recently, and how severely).				
	Assaulted anyone sexually (if yes, who, how recently, and how severely).				
	Assaulted or abused animals				
42.	Child has had any of the following problems at home or in the community.				
	Withdrawing socially (doesn't want to be around other people)				
	Lying or stealing				
	Arguing or fighting with peers or siblings				
	Clinging excessively to a parent, teacher or other person				
	Problems with police				
	Setting fires				
	Refusing to follow instructions from parents or obey house rules, etc.				
43.	Child ran away in past. (If yes,answer below)				
	For how long?				
	From where did child run?				
	Where did child go?				
	How was child returned? (Voluntarily, law enforcement, social worker?)				
	Why did child run?				
	Did/does child run alone or with others?				
44.	Child has had any of the following problems at school				
	Poor grades				

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		Yes	No	NK *	If "Yes", please comment
	Difficulty making friends				
	Suspensions from school				
	Fighting or arguing with peers or teachers				
	Frequent lying or stealing				
	Frequent truancy (including cutting classes)				
45.	Child has trouble sleeping. If yes, answer below:				
	Child takes sleeping pills. If yes, how often?				
	General sleeping pattern (sleep alone, cold or warm room, lights on or off, door open or closed, usual hours of sleep, naps, sleep with toy, pajamas, sleep walk, wake during night, etc.) (Circle appropriate description or describe:				
46.	Child has fears/phobias. If yes, answer below:				
	Darkness				
	Animals				
	Cars				
	Loud noises				
	Heights				
	Water (e.g., swimming pools, baths, lakes)				
	Weather (e.g., wind, thunder, storms)				
	Other (specify)				
47.	Child has a history of making abuse allegations against care providers				

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